

The MAP 351A Form (Revised 6/15/02)

The MAP 351A is to be used by Home and Community Based Waiver, Adult Day Health Care, Model Waiver II, Homecare Waiver, and Personal Care Assistance Waiver providers. The MAP 351A is designed to be a complete and thorough assessment of the patient that:

1. Can be used by the Peer Review Organization (PRO) to determine and validate the level of care and the appropriateness of services to be prior-authorized; and
2. Assists the providers in developing an appropriate plan of care.

General Information Regarding the MAP 351A

- The MAP 351A is to be used by waiver providers as an assessment document and shall be completed by the assessment team at each certification, re-certification, and reapplication. Once completed, the MAP 351A is to be forwarded to the PRO for level of care validation and supporting documentation in determining the appropriateness of services to be prior-authorized.
- Throughout the form there are "Comments sections" to provide the PRO with a better understanding of the applicant/recipient's difficulty. These entries serve as supporting documentation.
- Provide the applicant's name (last, first) and Medicaid Identification Number (Social Security number for individuals whose eligibility is pending) in the appropriate spaces at the top of each page.
- Completion and submittal of pages one (1) through nine (9) are **not** necessary when requesting a modification/amendment. Complete and submit MAP 9, MAP 10, and items 4-5 on page ten (10) for a modification/amendment.
- It is imperative that all questions be answered in their entirety. Failure to complete the form clearly and accurately will result in the return of the form to the waiver provider.

Section Instructions for Completing the MAP 351A

Section I – Recipient Demographics

This section compiles the recipient's demographics. Answer each question, **do not** leave blank or enter "N/A".

Name

Enter the applicant/recipient's full name (Last, First, Middle).

Date of Birth

Enter the applicant/recipient's date of birth (MM/DD/YYYY).

Medicaid Number

Enter the ten (10) digit Kentucky Medical Assistance number found on the recipient's Medicaid identification card. If the applicant's Medicaid eligibility has not yet been determined, enter the individual's social security number.

Street Address

Enter the street address where the applicant/recipient resides.

County Code

Enter the three (3) digit county code of the applicant/recipient's residence. For convenience, a listing of the county codes has been enclosed.

Sex

Check the box corresponding with the applicant/recipient's gender.

Marital Status

Check the box corresponding with the applicant/recipient's current marital status.

City, State and zip code

Enter the city, state and zip code where the applicant/recipient resides.

Emergency Contact (name)

Enter the name of the person whom the recipient or his legal representative designates as the emergency contact for the applicant/recipient.

Emergency Contact (phone number)

Enter the phone number of the individual designated as the applicant/recipient's emergency contact

Recipient phone number

Enter the phone number of the applicant/recipient or a number where he/she may be contacted.

Is recipient able to read and write

Check the box corresponding with the appropriate answer.

Recipient's height

Enter the applicant/recipient's height in feet and inches.

Recipient's weight

Enter the applicant/recipient's weight in pounds.

Section II – Recipient Waiver Eligibility

This section compiles information regarding the applicant/recipient's waiver eligibility. Answer each question in this section, **do not** leave blank or enter "N/A".

Type of program applied for (check one)

Check the box that matches the waiver program for which the applicant/recipient is applying.

Type of Application

Check the box corresponding with the appropriate type of application for the completion of this MAP 351A.

"Certification" refers to the applicant/recipient's application into the waiver program.

"Re-certification" refers to the recertification of a waiver recipient to obtain approval for continuing or on-going care.

Recipient admitted from (check one)

Check the appropriate box that accurately reflects the applicant/recipient's current situation. If "other" is checked, please define.

Certification period

Enter the beginning and ending dates (MM/DD/YYYY) of the certification or recertification period.

Has applicant/recipient's freedom of choice been explained and verified by a signature on the MAP-350 Form

Check the box corresponding with the accurate answer.

Has recipient been informed of the process to make a complaint

The applicant/recipient must be informed of the proper procedures for filing complaints. Check the box matching the accurate answer.

Home and Community Based Waiver/Adult Day Health Care Recipients and Model Waiver II recipients may file a complaint by contacting the Commonwealth of Kentucky, Office for Inspector General at 1-800-635-6290.

Homecare Waiver and Personal Care Assistance Waiver recipients may file a complaint by contacting the Commonwealth of Kentucky, Office of Aging Services at (502) 564-6930.

Physician's name

Enter the full name of the applicant/recipient's physician.

Physician's license number

Enter the five (5) digit license number of the applicant/recipient's physician.

Physician's phone number

Enter the phone number of the applicant/recipient's physician.

Enter recipient diagnosis(es)

Enter the recipient's medical/mental diagnosis(es) information requested in the order listed. Enter "none" in "secondary" and "others" only if there is not more than one diagnosis for the applicant/recipient.

Section III – Provider Information

This section compiles the waiver provider's information. Answer each question, **do not** leave blank or enter "N/A"

Provider name

Enter the name of the waiver provider.

Provider number

Enter the eight (8) digit provider number of the waiver provider entered in the "Provider name" entry.

Provider phone number

Enter the waiver provider's phone number.

Street Address

Enter the waiver provider's street address.

City, state and zip code

Enter the waiver provider's city, state and zip code.

Provider contact person

Enter the name of an individual with the waiver provider who may be contacted if there are any questions regarding information contained on the MAP 351A.

NOTE: The designated individual must be familiar with the applicant/recipient and the information contained on the MAP 351A.

Section IV – Activities of Daily Living

This section compiles information regarding the applicant/recipient's ability to participate in daily living activities. There are eight (8) questions in this section. Read each question and check the appropriate answer. If the answer is "yes", proceed to the next question. If the answer is "no", select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A"

Example: Using the first question, "Is recipient able to dress independently" the assessment team determines that the individual is unable to dress himself and the team marks the answer "no". Upon reviewing the supporting statements and evaluating the individual, the team then marks "Requires total assistance". Since the team answered "no" to the question, details must be provided in the "Comments" section. The assessment teams writes "Due to recent stroke, patient is unable to raise arms to dress self --- requires total assistance" as supporting documentation.

1. Dress independently

Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

2. Groom independently

Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Independent with bed mobility

Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Independent with bathing

Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

5. Independent with toileting

Check yes or no. If yes, proceed to question #6. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

6. Independent with eating

Check yes or no. If yes, proceed to question #7. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

7. Independent with ambulation

Check yes or no. If yes, proceed to question #8. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Independent with transferring

Check yes or no. If yes, proceed to Section V. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

Section V – Instrumental Activities of Daily Living

This section compiles information regarding the applicant/recipient's ability to perform complex tasks essential in community living. There are eight (8) questions in this section. Read each question and check the appropriate "yes" or "no" answer. If the answer is "yes", proceed to the next question. If the answer is "no", select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A".

Example: Question #6, "Is recipient able to obtain and take medication independently", the assessment team determines that the applicant/recipient is unable to do so and marks "no" on the form. Upon reviewing the supporting statements contained on the form, the team marks "Arranges for medication to be obtained and taken correctly". The assessment team writes, "The patient's daughter obtains medication on a monthly basis and arranges it in a medi-planner for her mother each week" as supporting documentation.

1. Meal preparation

Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statement and provide detailed information in the "Comments" section.

2. Independent shopping

Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Light housekeeping

Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Heavy housekeeping

Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

5. Laundry tasks

Check yes or no. If yes, proceed to question #6. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

6. Obtaining and taking medication independently

Check yes or no. If yes, proceed to question #7. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

7. Handling finances independently

Check yes or no. If yes, proceed to question #8. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Independent usage of telephone

Check yes or no. If yes, proceed to Section VI. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

Section VI – Mental/Emotional

This section compiles information regarding the applicant/recipient's mental and emotional health. There are six (6) questions in this section. Read each question and check the appropriate answer. If required, select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A".

1. Behavior problems

Check yes or no. If no, proceed to question #2. If yes, check the applicable, supporting statements and provide detailed information along with the frequency in the "Comments" section.

2. Recipient mental diagnosis

Check yes or no. If no, proceed to question #3. If yes, check the applicable diagnosis and enter the date-of-onset. Provide detailed information in the "Comments" section.

3. Recipient orientation to person, place and time

Check yes or no. If yes, proceed to question #4. If no, check the applicable statements and provide detailed information in the "Comments" section.

4. Major change or crisis

Check yes or no. If no, proceed to question #5. If yes, provide detailed information in the "Description" section.

5. Social and/or community activities

Check yes or no. If no, proceed to question #6. If yes, provide detailed information in the "Description" section.

6. Recipient history

Check the applicable, supporting statements and provide detailed information along with the frequency in the "Comments" section.

Section VII – Clinical Information

This section compiles information regarding the applicant/recipient's clinical background. There are nineteen (19) questions in this section. Read each question and check the appropriate answer. If required, select all of the appropriate supporting statements and provide detailed information in the "Comments" section of the form. Each question must be answered, **do not** leave blank or enter "N/A"

1. Adequate vision

Check yes or no. If yes, proceed to question #2. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

2. Adequate hearing

Check yes or no. If yes, proceed to question #3. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

3. Communicating needs

Check yes or no. If yes, proceed to question #4. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section.

4. Adequate diet

Check yes or no. If yes, proceed to question #5. If no, check the applicable, supporting statements and provide detailed information in the "Comments" section. If "Tube feeding require" is checked, provide the brand, amount, and frequency in the "Comments" section.

5. Assistance with breathing

Check yes or no. If no, proceed to question #6. If yes, check the applicable, supporting statements and provide as much detailed information as possible in the "Comments" section. The information in the "Comments" section is to include the status of the applicant/recipient's respiratory condition (i.e. stable, declining, weaning). If "Oxygen therapy" is checked, provide the liters per minute and deliver device in the "Comments" section. If "Ventilator" is checked list the settings in the "Comments" section.

6. History of stroke(s)

Check yes or no. If no, proceed to question #7. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section. If "Functional limitations" is checked, provide number of limbs affected in the "Comments" section.

7. Skin care

Check yes or no. If no, proceed to question #8. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

8. Routine lab work

Check yes or no. If no, proceed to question #9. If yes, provide details, including the type and frequency, in the "Comments" section.

9. Genital and/or urinary care

Check yes or no. If no, proceed to question #10. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

10. Physician ordered vital sign evaluation

This question refers to **physician** ordered vital sign evaluation (i.e. orthostatic blood pressure). Check yes or no. If no, proceed to question #11. If yes, provide detailed information in the "Comments" section including type of evaluation order by the physician and frequency.

11. Total or partial paralysis

Check yes or no. If no, proceed to question #12. If yes, provide detailed information in the "Comments" section including the limbs affected.

12. Changes in body position

Check yes or no. If no, proceed to question #13. If yes, check the applicable, supporting statements and provide detailed information in the "Comments" section.

13. 24 hour caregiver

Check yes or no and proceed to question #14.

14. Respite services

Check yes or no. If no, proceed to question #15. If yes, provide the frequency the service is required.

15. Intravenous fluids, IV medications or IV alimentation

Check yes or no. If no, proceed to question #16. If yes, check the supporting statements and provide the requested information, including the solution, location, amount, rate, frequency and prescribing physician.

16. Drug allergies

List any known drug allergies and type of reaction, if known (i.e. penicillin – hives). If there are no known allergies, enter “None”, “NKDA” or “NKA”.

17. Other allergies

List any other known allergies and type of reaction, if known (i.e. shellfish – respiratory distress or medical/surgical tape – blisters). If there are no other known allergies, enter “None” or “NKA”.

18. Medications

Check yes or no. If no, proceed to question #19. If yes, list each medication and provide the name of the medication, dosage/frequency/route and the name of the person who administers the medication (i.e. self, son, caregiver, RN, etc.). If more space is required, attach additional pages as needed.

19. Adaptive equipment

Check has, needs or N/A for each item listed. For items that are checked needs, provide details in the “Comments” section.

Section VIII – Environmental Information

This section compiles information regarding the applicant/recipient's physical environment. There are two (2) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Physical environment

Check yes or no for each item listed. If no, provide detailed information in the "Comments" section when appropriate. For example, the item "Accessible" is checked "no". An appropriate comment may be "Patient's doorways are not wide enough to accommodate his wheelchair."

2. Inventory of home adaptations

List and provide detailed information regarding any home adaptations already present in the applicant/recipient's home.

Section IX – Household Information

This section compiles information regarding the applicant/recipient's household. There are two (2) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Recipient residing alone

Check yes or no. If no, proceed to question #2. If yes, check the appropriate answer regarding assistance from others. If the applicant/recipient is receiving assistance from others, provide detailed information.

2. Household members

Provide the name, relationship and age of the applicant/recipient's household member(s). Check yes or no if the individual is functionally able to provide care. If no, provide a detailed explanation in the "Comments" section. If yes, provide detailed information including the type of care provided and frequency in the "Comments" section.

Section X – Additional Service Information

This section compiles information regarding any additional services the applicant/recipient is receiving. There are five (5) questions in this section. Each question must be answered, **do not** leave blank or enter "N/A".

1. Hospital or nursing facility admissions

Check yes or no. If no, proceed to question #2. If yes, provide the facility name, facility address, reason for admission, admission date and discharge date in the appropriate spaces.

2. Services from other agencies

Check yes or no. If no, proceed to question #3. If yes, provide the type of service, agency/worker name, agency/worker phone number, agency address, frequency service provided and number of units (if applicable) in the appropriate spaces.

3. Traditional home health services

Check yes or no. If no, proceed to question #4. If yes, provide the anticipated home health discharge date, type of service, visits (indicate per week or per month) and type of coverage (indicate Medicare, Medicaid, private insurance and/or private pay) in the appropriate spaces.

4. Summary

Check certification or amendment/modification and summarize the applicant/recipient's assessment in the space provided. It must be signed and dated by the member(s) of the assessment team who completed this section.

5. Assessment team signatures

Both members of the assessment/reassessment team must sign, provide their titles and date the MAP 351A form in this section.

6. PRO signature

This area is reserved for use by the Peer Review Organization. **Do not** complete this area.